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ABSTRACT

In early 1966, the Denver Department of Health and Hospitals embarked on a city-wide, decentralized health program in an effort to provide family centered "team" health care to medically indigent patients. The program encompasses 28 different clinics and facilities. Factors hindering or influencing the final pattern of health care delivery include: (1) federal funding agencies' guidelines and biases; (2) grossly underestimated health care demands by an unlimited population load; (3) differences among family members for facility, hours of service, and health care provider; and (4) difficulties in the recruitment of scarce health professionals. After experimenting with many different patterns of team care and leadership, a workable model emerged using the combination of a neighborhood aide and a backup social worker as the basic core for family-centered health care. The social worker is responsible for forming a flexible "Health Team" to meet the needs of a particular family. A central social service register, decentralization of personnel, and constant administrative support are essential. (Author)

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# FAMILY CENTERED HEALTH CARE -- A VIABLE REALITY?

## The Denver Experience

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FAMILY CENTERED HEALTH CARE - A VIABLE REALITY?
The Denver Experience

David L. Cowen, M.D. and John A. Sbarbaro, M.D., M.P.H.

During the past decade the winds of social change have had their impact upon the American health care system. By Congressional decree, political declaration, and administrative fiat, adequate health care has been championed as the right of all Americans. Marked increases in funding provided by many federal, state and local agencies have pushed American medicine into the uncharted ocean of the organized delivery of health care. Exciting, but unproven and undocumented phrases have become national goals overnight. "Community Participation," "Consumer Control," "Comprehensive Family-Centered Health Care," "Innovations in Health Care" and "Neighborhood Workers" have become the language of our time and have ridden on the tide of emotion of "The Great Society." On occasion an unproven slogan has been accepted as a standard to which unending loyalty is pledged and whose legitimacy, thereafter, has not been questioned. This paper is concerned with the legitimacy and viability of one such standard: The concept of Family-Centered Health Care.

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BACKGROUND

During the past few years the American health care system has been subjected to analysis, condemnation, and extensive press coverage. The one consistent theme has been that our current system is not meeting the needs of our society. The causes of this failure are multiple and include the changes that have been modifying the American family. The extended family, once a significant part of the American scene, is being fragmented into nuclear families and even single individuals. Urbanization, increased longevity, the automobile, and affluence have all been blamed. Regardless of the cause, it must be recognized that an isolated nuclear family is exquisitely sensitive to the disruptive pressures accompanying social, economic, or personal change. With the support of the extended family removed, a medical crisis can more readily impair the effectiveness of a nuclear family and its individual members. When this social trend is combined with the subspecialization drives of the medical profession and the mobility of all society, one can almost guarantee a sense of isolation, a harking back to the good old days of the family "doc", and fragmented, ineffective and impersonal health care.

As health planners attempted to improve upon this complex situation, they recognized several basic truths:

1. Physical, mental, environmental and social components of health cannot be separated.

2. Many professional skills must be brought to bear upon a patient if the full benefits of modern medicine and our society are to contribute to a solution of the problem.
3. Physical, financial and cultrual barriers often cause less advantaged persons to be the most medically deprived.

Adopting the nostalgia of the past, a program of "Neighborhood Based, Family-Centered Comprehensive Team Health Care" was envisioned. The Office of Economic Opportunity has been the most responsible and aggressive Federal Agency in the attempt to develop and implement this new approach. In the past several differing patterns of delivery have been tried in attempting to bring this catchy phrase into reality. These programs have met with varying effectiveness.

## REVIEW OF VARIOUS PROGRAMS AND MODELS PROVIDING "FAMILY-CENTERED CARE"

An early model which generated much enthusiasm was the Family Health Maintenance Demonstration of the Monteforie Medical Group[1,2]. Using an internist, pediatrician, public health nurse, and a social worker as the basic team, the Monteforie Medical Group designed a methodological study to determine what health services were necessary and how best a family could be motivated towards health. The health

team was organized to provide both preventive and therapeutic medical care. Medical specialists, a health educator, psychiatrist, psychologist,and a social scientist were included as consultants to the basic medical team. Fewer than 150 families were involved in the overall study. An analysis of the study families reveals that all of the fathers were working (41 percent were employed in a professional or semiprofessional field). The educational levels of both parents were above the national and local average. Furthermore, each family was selected from a population interested enough in health to seek care under the Health Insurance Plan of New York. It is interesting that only 57 percent of the original pilot families agreed to participate in this family approach.

Dr. George A. Silver, innovator of the experiment, concluded the Family Health Maintenance Demonstration was successful in improving the physical health of the study families (49 percent improved and 15 percent deteriorated). He noted no change in the emotional area. In fact, when compared with the control families, the data suggested emotional deterioration may have occurred. This observation is probably invalid, being produced by the close relationship of the study group and evaluators. Mothers from the lower social classes contributed very little to

the physical improvement of the study group whereas lower social-class fathers constituted a major portion of the physical improvement. The demand for medical services varied with the economic group, being least for families in the lower social strata. This observation has been confirmed by other studies[3].

The participating families rated the team members in the following order of desirability: Physician, nurse, clerk and social worker. Although the public health nurse was accepted by the families as having a medical role to play, the social worker was distrusted particularly by those families lower on the occupational scale. Generally, the social worker was not considered by patients to be a significant part of health services. Dr. Silver attributed this failure to the patient's impression that needing a social worker was equivalent to acknowledgement of a psychiatric problem or a disturbed family relationship. Nevertheless, the interviews conducted by the social worker provided valuable information to the team in developing attitudes not only towards the families, but also towards their own professional roles. Social workers, therefore, were quite valuable to the total medical effort.

Dr. Count Gibson[4] has also achieved national recognition as a

strong proponent of Family-Centered Health Care. In his initial efforts at the Columbia Point Neighborhood Health Center, Dr. Gibson assigned internists to an adult care area and pediatricians to a separate children's unit. Nurses worked in the community while the social workers functioned in a separate section of the Center. Initially, the program relied on ad hoc conferences to achieve family coordination. Finding coordination difficult, Dr. Gibson reorganized the Center into four family health care team units, each caring for 350 families. The team members met once a day for half an hour to develop plans for families under active care. Prenatal, gynecological services, and family planning was integrated into each family health care group by having the obstetrician spend one half day a week in each area. Dr. Gibson added much to our understanding with this approach, but some difficulties were encountered. The community soon learned that if a person did not like the physician to whom he was assigned, he could request another physician. Upon his transferring to another physician, however, his entire family was also required to make the changeover. This reassignment produced duplication of effort by the other professionals and interruption of established professional/patient relationships.

No evaluation was made as to the impact on the community of this

arrangement, the percentage of pateints requesting transfer to another physician and the cost per patient of this experiment. The Center was able to restrict its services to a defined population living within the Columbia Point Housing Project.

The Gouverneur Ambulatory Care Unit of the Beth Israel Hospital[5] stated its purpose was to provide comprehensive medical care of high quality in a way that would best meet the total needs of the lower eastside of New York. Subspecialty clinics were eliminated while the basic specialties of medicine, pediatrics, and general surgery remained. The goal was to have one internist for each adult patient and one pediatrician for each child. Subspecialty consultation was usually obtained from the Beth Israel Hospital although the use of specialty skills of the Unit staff was encouraged. In essence, the Gouverneur Ambulatory Care Unit was a hospital general-medical outpatient department which utilized many group practice patterns to provide care to the poor.

The Unit was detached physically and, to a significant degree, administratively from the Hospital. Dr. Howard Brown and Dr. Raymond Alexander noted that frequently the inpatient service so dominates the interests of a hospital that little attention is given to adapting the outpatient services to the needs of the

patients. They felt this was one of the advantages of physically detaching the outpatient unit from the hospital.

The concept of the "health team" was re-introduced by Dr. Jerome Beloff and Dr. Richard Weinerman[6] who determined that effective family health maintenance implies a unified, personalized and continuous service system. Their basic health team consisted of a physician, a public health nurse and a community health aide with supporting consultants in the medical specialties, social work, nutrition and other fields. Its purpose was to coordinate the efforts of medical and paramedical personnel in an experimental model of a neighborhood health center at the Yale-New Haven Medical Center[7]. This service unit was visualized as both providing health protective services and functioning as a bridge between the health needs of the member families and the appropriate scattered resources of the community. It is of interest to note that this program is nearly a duplicate of research conducted at the Denver General Hospital during 1956-59 by Dr. Fred Kern[8].

Utilizing medical students as primary physicians with supporting internists and pediatrician preceptors, a carefully controlled number of families was selected from the neighborhood. Dr. Beloff noted that if a neighborhood health center were to provide comprehensive and continuing care, it was advisable to involve

families only on an application or referral basis. Were this method not followed, the facilities and personnel would be wholly absorbed in providing episodic medical care to individual patients. A family health record was maintained for each family. This record included the family demographic data, immunization records, chronological treatment log of all family contacts, public health and social work assessments, and the medical progress notes of family importance. Although each member of the family underwent a complete medical workup, special social work evaluation was undertaken only as indicated in the individual family situation. A family health plan was then developed and recorded by the student physician and later modified by a full health team discussion. Each team held a conference immediately following each patient care session to discuss any problems encountered since the previous session. Psychiatrists and social workers were asked to attend. In an effort to evaluate the effectiveness of the health maintenance plan as well as modify the program when indicated, three-month review conferences were to be held between the student physician and appropriate consultants for problem families.

Dr. Beloff felt his health team would overcome the traditional barriers to free interdisciplinary communication. He used the

public health nurse in the major role of establishing, implementing and coordinating the family health plan. The public health nurse became the health advisor to the family. A neighborhood health aide was enlisted to make the first approach to the family and arouse its interest in the health care program. Later, the aide assisted in maintaining a continuing communication between the member families and the staff. The nurse and aide functioned in both the home and family health unit[9].

Unfortunately, the initial efforts of this program toward the development of team medicine ran into the traditional medical background of faculty members who allow little responsibility for patient care to be given to paramedical colleagues. Weekly seminars and improved communication techniques resulted in some change. Program emphasis shifted so that patient and family health needs are now served by the most appropriate team member. This experimental effort was able to care for a total of 45 families within a 30-month period.

The many attempts of university medical centers to develop comprehensive care programs are well summarized by Dr. Parney Snoke and Dr. Richard Weinerman[10]. In evaluating the existing system of patient care, they conclude that only a small proportion of patients from the general community can actually receive full

comprehensive care within the walls of a university medical center. Two reasons are presented to support this conclusion: (1) Such institutions must function as the referral resource for the rest of the community, and general medical care can quickly dilute this effort; and, (2) The organizational requirements for optimal patient care differ in many ways in emphasis, design, and function from the requirements for good clinical teaching. Dr. Snoke hypothesizes that a specially organized academic family health care unit is required if truly comprehensive medicine is to be demonstrated while maintaining an effective educational environment. The authors provide an excellent bibliography describing university programs aimed at achieving this goal. Most of the 20 documented programs include a full-time internist, a pediatrician, a medical social worker and a public health nurse. The nurse functions either as the coordinator or simply as a member of the team; students, however, become the focal point for family-centered care. The paramedical personnel were used as consultants in most of the programs.

The authors conclude that no widely accepted pattern for the provision and teaching of comprehensive medical care has yet developed. Dr. Snoke notes most programs did recognize the value of coordinated service for family groups as well as the

significance of personal and social factors in disease. As expected, most programs emphasized education over service and limited their service to a small number of patients.

More important than the academic and educational problems involved in the delivery of family-centered health care are the overriding and yet unanswered questions:

1. Is family-centered care beneficial for all or some patients, for the professional, or for no one?
2. Can family-centered care be made available to large population groups?

Except for Dr. Silver's evaluation of a highly selected and small population, none of the aforementioned manuscripts have faced these issues. All have assumed that a family-centered comprehensive approach is a proven good, an acceptable goal and an achievable reality. Furthermore, each of these programs, with the exception of the Gouverneur Outpatient Department, has been aimed at restricted patient loads. None has developed a model for a family-centered team approach that has been put to the test with large scale population loads. No program has produced data that indicates the family-centered approach has achieved either long-term patient or professional acceptance.

The overall problems of family-centered care are concisely presented in a recent editorial in the New England Journal of Medicine[11]. The editor pinpoints the difficulty in coming to grips with the paradoxical goal of creating integrated health teams of nurses, sociologists, psychologists, allied health personnel, and physicians to render family services, and yet, provide the patient a physician whom he can identify as his own - one to whom he can turn, confident that treatment and diagnosis will be based in the broadly developed knowledge of an understanding fellow human.

## THE DENVER NEIGHBORHOOD HEALTH PROGRAM

With these problems in mind, the Denver Department of Health and Hospitals initiated the development of the Denver Neighborhood Health Program which it has nurtured during the past five years. In 1966 the Department began implementation of its city-wide program of health care delivery. An organized system of health care was envisioned, emphasizing ambulatory physical, mental, social, and dental services provided through neighborhood-based facilities, and utilizing the inpatient and specialty services of its municipal hospital, Denver General. Interdispersed throughout the program are public health functions such as nutritional counseling, home nursing, health education, disease control and

environmental health services. Although the health and hospital functions of the Department had been combined since 1912, this was the first time that the reality of delivery approached the theoretical concept of a combined agency. The program was designed to demonstrate that:

1. The combination of mental health, physical health, and public health services into a single coordinated attack could effectively meet the problems of a core city.
2. A unified program could efficiently utilize limited finances and scarce skills of health professionals.
3. A program serving an unlimited population base would be highly acceptable to patients who had previously been alienated by the traditional city hospital approach.

Many of the successes and some of the failures of this program have been documented in other publications[12, 13, 14]. The purpose of this paper is not to reiterate those efforts, but rather to critically examine one element of the program that was considered central to its development. This element is the avowed purpose to deliver family-centered health care. It is hoped that a brief

description of the Denver attempt to implement this concept will be of value to other programs, to health educators and to planners alike.

The health philosophers had painted a marvelous picture of the potential benefits of comprehensive family-centered care. Earlier, the researchers had offered hope that such program goals could be achieved. The demonstration of a comprehensive program directed at a large, relatively unlimited population, however, soon revealed some rather harsh realities:

1. Granting agencies, while espousing the unified goal, often limit its attainment by dictating program services and procedures--that is, Maternal and Infant Care Grants require that most mothers be seen by a physician who is certified by the American Board of Obstetrics, Gynecology, and the Children and Youth Projects demand specified services and care by a pediatrician.
2. The volume of health need in the core city is grossly underestimated. On the basis of the accumulated wisdom of both Washington officials and our Agency, Denver's first health center

was designed and initially staffed to serve 450 patients per week. Within a short period of time, 1500-2000 patients were visiting the Center weekly. The number of program patient visits has soared from 100,000 in 1965 to 600,000 in 1969. The resulting pressure for care, of necessity, modifies the approach to care.

3. Patients in the poverty areas have many of the traditional values of our middle-class ethic. They want their "personal physician". While accepting any physician when critically ill, they will "shop around" when less critically ill. Change of physician or health facility is often based on word of mouth from friends, neighbors, rumor, and superstition -not on their medical needs- or on staff availability or quality of care. The poverty patient has demonstrated he is no more ready to accept a nurse, social worker, or other allied health professionals or physician substitute than is his more affluent counterpart.

4. The current product of our medical schools often is not trained nor interested in handling the full spectrum of family health problems. There is hesitancy in accepting other allied professionals and nonprofessionals as being capable of giving or being involved in quality care.

5. Recruitment of health professionals is a difficult and unending process. The available help often dictates the manner in which care is delivered.

In 1966 some of these realities were recognized, some were yet to be learned; nevertheless, Denver's first health center was opened in March. All traditional health services were represented. Comprehensiveness of care was emphasized through the presence of mental health workers, social service, nutrition, public health nursing, environmental health, dentistry, family planning and "neighborhood aide" outreach. In addition, the program provided a transportation network to and from the center and back-up hospital. Baby sitter services were available in the health center.

The center was immediately inundated with patients. It quickly became apparent that to assure a responsive appointment system

thus maintaining the capability to provide continuous one patient-one physician medical care, a classic "drop-in" or "episodic treatment" clinic was needed. Each physician, therefore, assigned ten percent of his time to meet this need. These physicians were expected to follow each new case later on an appointment basis. A neighborhood aide was assigned full time to encourage these newly registered patients to take advantage of the appointment system and to further assure that they would have an opportunity to see their physicians even when re-entering the system as a "drop-in".

An additional device was used in an attempt to assure family linkage into this system - the "Family Summary" (see Figure I). This medical record was conceived to assure that the caregiver was informed of the existence and health status of other family members. It includes the date, diagnosis, and medical and ancillary service visits of each family member. The Summary was to be kept up to date, and xerox copies were to be placed in the chart of each family member.

Case conferences were planned so that the "collective wisdom" of all professional skills of the center could be brought to bear upon patient problems.

The constraints noted earlier immediately became apparent and

took their toil. Frequent evaluations of the physicians' use of the "Family Summary" during the first 18 months of the program indicated that, despite frequent encouragement, Family Summaries went unused by the physicians. The physical disease orientation and academic specialization of our physicians ill-prepared them to think of the patient as a family member in the setting of his home with its full social and economic implications. Individual diseases were treated; on occasion, the entire individual was treated. Seldom was an overall family plan developed by the physician.

This finding, together with the unexpected volume of patients, the tendency of patients to change physicians, and of physicians to refer patients, had a devastating effect on our efforts toward developing family-centered care. Case conferences, although held on a weekly basis, were poorly attended because of the overriding need to attend to the daily demand for patient services. The Family Summary was, at best, partially kept up to date and then, only through a major effort and diversion of resources. Although we have anecdotal evidence that problem families frequently did receive an overall unified-family approach from the health center, it occurred in a nonstructured manner and was primarily based on the excellent relations between ancillary services.

## THE HEALTH STATION CONCEPT

In March 1967, federal funding permitted the opening of the first of nine small further decentralized health facilities. The health station gave renewed hope that family-centered care could be a reality. Less than one sixth the size of a health center, it was hoped that the close physical proximity of the smaller health station staff would permit a more rapid development of team effort. Problem families would quickly become apparent to everyone, and impromptu conferences would result in a united approach. Major team conferences would then be required by only a few cases.

The stations were significantly more successful in developing a modicum of family-centered care although, certainly, their attainment was frequently spotty and difficult to assess. Nevertheless, as a result of the experiences at the center and in the developing stations, a pattern which seemed to meet both the needs of the patients and the needs and limitations of the professional was developed. The coordination of the program's overall family-centered approach was to be given to a nonphysician specialty since experience in the stations showed that most of the conference time and most of the unresolved problems concerned social, economic and disease complexes, not traditional medical disease entities. Family care appeared to require personnel with the ability to assess the total family from both a general health

and a social point of view, plus a sophisticated knowledge of the overall resources available in the community. Other qualities that were deemed desirable included the ability to communicate with the patient and other professionals, and the capability of empathy with the patient and his family.

After rejection of the physician, the public health nurse was considered as this coordinator for family-centered care. The excellent communication network and administration afforded by the Denver Visiting Nurse Service made it an attractive choice. Selection of the nurse also had a great deal of appeal since most of the previously mentioned studies used nurses. Moreover, many individuals of national stature and the Office of Economic Opportunity were proposing health teams with a nursing base. The development of clinic management and the training of indigent workers as ward clerks, nurses aides, etc., was most easily accomplished by R.N.s, yet these people did not operate well in the community. Home care was most adequate when provided by nurses who had obtained a public health nurse background. Initially, it was most difficult to recruit public health nurses to a medical clinic since they did not find this limited role rewarding. An additional problem in using the public health nurse in such a role was the extreme mobility of this group. Like many other agencies, we experience a 30-50 percent annual

turnover in nursing staff. This turnover unquestionably would have an effect on the long-term rapport required to affect a family health pattern.

It was recognized early that an individual with the same cultural background in poverty, prejudice, and hopelessness would be more likely to understand the full social and economic implications of a patient's problems. Understanding was not enough, however, since the person frequently would not have the professional training or expertise to effectively deal with professionals and marshal community resources. In attempting to develop a family-centered team using neighborhood aides and public health nurses, considerable effort was expended in shoring up the professional weaknesses of the aides. This effort was abandoned because it did not make maximum use of the aides' strengths - namely, their knowledge of the social need of their counterparts in the neighborhood. Their role as assistants to nurses was difficult to define and develop. Moreover, we found that leaders in nursing were hesitant to develop a dead-end-subprofessional role for neighborhood aides as inadequately trained public health nurse surrogates. For these reasons, after a very brief attempt to follow the lead of other centers, the public health nurse was rejected as the leader of the family-centered health team.

Our ultimate resolution of the problem was to reassign as many of our neighborhood aides as possible to our Social Service division and then charge that division with the responsibility of coordinating the Agency's family-centered approach. The combination of a neighborhood aide and a back-up social worker was visualized as the basic core for family-centered care. Each social worker was assigned approximately four neighborhood aides designated as Family Health Counselors. The neighborhood aide was to act as an information gatherer and an interpreter for both the patient and the professional with the guidance of the social worker. The aide could improve in her ability to assess the total family from a general health and social point of view. Problems too great for the Family Health Counselor were then referred to the back-up social worker who could bring further resources to bear upon the particular family. The social worker, when necessary, formed a "health team" to meet the needs of a particularly difficult family and focused the efforts of the team through the neighborhood aide to that family.

We have found this responsibility to be well accepted by the social workers and rewarding for the neighborhood trainees. Overworked social workers are quite willing to develop new roles for indigent staff, and with the precedent set, the program is

then able to attract dynamic and innovative professionals. The combination of neighborhood aide and social worker apparently eliminated the predicted distrust of the social worker who, nationwide, is cast with the hated welfare system. We have seen no rejection of this combination by our patients. Perhaps the association of the social workers with a system accepted by the community is the real factor behind their acceptance.

Holding the Social Service division responsible for coordinating the family-oriented efforts of the Agency has led to the development of respect and cooperation between various professional groups. Constant administrative support and encouragement was necessary during this transitional period. The increasing self-respect and assertiveness of the social worker overcame the physicians' lack of awareness of their value. This change was manifested by physician demands for the decentralization of the health center social workers into the direct care medical units of the center (each staffed with two to three physicians). Moreover, the coordination provided by Social Service has enabled us to permit various specialty groups (Internal Medicine, Pediatrics, and Obstetrics-Gynecology) to work in clusters. These professional clusters improve scheduling and cross-communications on difficult medical problems and allow for unexpected physician absences.

This program approach provided the distinct advantage of

maintaining a flexible team in which different professionals could be included for particular problems and eliminated from the health team upon resolution of that problem. Only the health personnel necessary for problem resolution were drawn together by the social worker. The physician, rather than being the focal point for problem resolutions, became a technical advisor and caregiver. Areas in which the physician had no training were handled by other better trained, less expensive, and more readily available professionals. This model overcame many of the difficulties surrounding the previously described less flexible team approach. When the team is prestructured and families arbitrarily assigned, many inefficiencies develop. A patient-physician conflict or, for that matter, any personnel-patient misunderstanding may result in a partial breakdown in rapport. The resulting alienation then requires the reassignment of the entire family to another team with much duplication of effort. Such a problem in the more flexible approach results in the change of only one team member and maintenance of all other relationships.

Large scale programs schould not and cannot dictate that each and every patient receive a family-centered team approach. This reality has proven to be well accepted by the professional and

patient alike. Many patients do not require nor will many accept such a total effort. Some staff do not work well in a team, but provide valuable, and sometimes irreplaceable, professional care in a more traditional manner. A centralized Social Service family registry overcomes the difficulties imposed by our finding that different members of a family may seek care at different facilities at any hour. Any "system" of health care serving large populations through decentralized facilities must accept this patient mobility and adapt its professional programs to its consumers' demands.

We have found that approximately 45 percent of the families seeking care in our program require and benefit from a family-oriented team approach. Families in turmoil are rather readily apparent to most any professional and are quickly included in the program. Identifying borderline cases has proven more difficult. The "Family Summary" was not of value, and attempts to have either every patient or chart seen by a social worker have failed because of personnel shortages and patient resistance. The Agency is now experimenting with the use of problem-oriented charting methods. It is hoped the problem approach will permit us to extend our program to more borderline cases.

## SUMMARY

In summary, a modified team approach to comprehensive "family-centered" health care developed in the Denver Neighborhood Health Program has been presented along with a review of the literature pertinent to the subject.

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# NEIGHBORHOOD HEALTH PROGRAM — DENVER DEPT. OF HEALTH AND HOSPITALS — FAMILY SUMMARY RECORD

Family Name: Griffin

Economic Status: Poverty ☐ Deprived ☐ Adequate ☐

Ethnic Group: A ☒ N ☐ S ☐ Other ____

Family Filing No.: A00-00-00

CODES – C-Clinic Nurse, D-Dental, E-Environmental Health, H-Health Education, M-Medical, N-Nutrition, P-Mental Health, R-Referral, S-Social Services, V-VNS

| Name | Age | Sex | House-Hold Status | VISIT DISPOSITION | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Date | Code | Date | Code | Date | Code | Date | Code | Date | Code |
| JANE | 30 | F | Head | 3-7-66<br>Cystitis, Diabetes, Obesity | M | 3-9-66<br>Diabetic Diet, Weight Control Problem | N | 3-11-66<br>Home visit-Asst. with Insulin | V | 3-15-66<br>Missed Appointment | M | 3-16-66<br>Home visit-Follow-up of Missed Appointment. | S | 4-3-66<br>R.V. Diabetes, Cystitis, resolved. | M |
| | | | | 4-3-66<br>Weight reducing Diabetic Diet | N | 5-10-66<br>BW X-rays, Exam | D | 5-10-66<br>R.V.-Diabetes Obesity | M | 5-10-66<br>Financial Problems | S | | | | |
| MARY | 6 | F | D | 3-8-66<br>ARD | M | 3-11-66<br>Pneumonitis | M | 3-12-66<br>Home Visit Check Medication | V | 3-15-66<br>Pneumonitis, Resolving | M | 4-12-66<br>Well Child Immunizations | M | 5-10-66<br>Exam Prophy | D |
| PETE | 13 | M | S | 3-12-66<br>Conjunctivitis, Referral-Eye Clinic | M | 3-13-66<br>Eye Clinic Conjunctivitis, Severe | M | 3-21-66<br>Eye Clinic Conjunctivitis, Cleared | M | 3-21-66<br>Adjustment Reaction of Childhood. School Referral | P | 4-3-66<br>BW X-rays Exam | D | 4-20-66<br>Same Group Therapy | P |
| | | | | 5-10-66<br>Prophy. | D | 5-12-66<br>T.R.<br>Fracture, left radius.<br>Fell at home | M | 5-14-66<br>Investigation of broken stair way at pt. home | E | | | | | | |